State of New Hampshire
Department of Health and Human Services
Division of Community Based Care Services
Bureau of Elderly and Adult Services

SFY 2011 Case Management Program Evaluation

Brain Injury Association

January 2011

Prepared by:

Division of Community Based Care Services
Quality Management

January 2012

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Executive Summary

The Division of Community Based Care Services (DCBCS,) in its commitment to the principles and activities of quality management established a division wide quality management philosophy and infrastructure which included a Quality Leadership Team, facilitated by the Deputy Director, and which is comprised of representatives from the DCBCS bureaus. A number of performance indicators were identified that address either system performance, safety, participant safeguards, participant outcomes and satisfaction, provider capacity, or effectiveness.

One of these performance indicators was to perform annual site visits of the independent case management agencies for the purposes of assuring that the home and community based care elderly and chronically ill waiver program participants' service plans were appropriate, person-centered, that the delivery of services was timely and that the case management agencies had the capacity and capability to deliver or access the services identified in the participants' service plans. This task was subsequently included in the 2007 application for the Home and Community Based Care – Elderly and Chronically Ill waiver as a component of the quality management section of the waiver and is identified as a performance measure for several quality management assurances.

The first annual program evaluation reviews for the five independent case management agencies were completed in May and June of 2009 and were based on the Targeted Case Management Services rule, He-E 805, which was adopted effective August 26, 2008. Program evaluation protocol and a review instrument were developed by a committee that included BEAS staff and which were shared and discussed with the five licensed case management agencies that served participants in the HCBC-ECI waiver program, also known as the Choices for Independence (CFI) program.

The 2009 program evaluation focused on the required case management services of (1) developing a comprehensive assessment, (2) developing a comprehensive care plan and (3) monitoring the services provided to the Elderly and Chronically Ill waiver program participants. A sample of cases was reviewed by a team comprised of staff from the Bureau of Elderly and Adult Services (BEAS) state office, the DCBCS Quality Leadership Team and BEAS Adult Protective Services field staff. The sample size for each agency was determined through the use of a statistical program used by the Bureau of Behavioral Health in its annual eligibility and quality assurance reviews.

Each case management agency received a report that included the results for each of the 38 questions and, when applicable, recommendations for improvement. The agencies were required to submit a quality improvement plan that addressed each recommendation within sixty days of the receipt of its program evaluation report.

BEAS also committed itself to its own quality improvement activity by reviewing the 2009 case management program evaluation process, protocol and review instrument. The results were a reduced number of questions from 38 to 21, the use of a statistical application recommended by the National Quality Enterprise[1] consultants that identified a representative statewide sample for the SFY 2011 program evaluation, and the decision not to rate the timeliness and quality of initial assessments and initial care plans for those cases opened prior to the adoption of the rule, i.e., August 26, 2008, for the SFY 2011 program evaluations.

The protocol and instrument included a four point rating scale, as indicated below:

0	Not applicable, e.g., activity occurred prior to effective date of applicable rule
1	Does not meet minimal expectations, e.g., documentation is missing
2	Meets minimal expectations as established and described in rule
3	Exceeds minimal expectations, i.e., example of best practice

The goal for the initial case management program evaluation was to complete an evaluation on all five of the case management agencies within a few weeks in order to establish a baseline for each agency and for case management for the CFI waiver program as a whole. Going forward, it is anticipated that a complete case management program evaluation will be held annually with each agency that provides case management services to CFI participants. It is anticipated the program evaluation protocols will expand to address additional components of the Targeted Case Management rule, include other pertinent questions and a financial component. These are the goals of the 2010-2011 BEAS Case Management Program Evaluation scheduled bi-monthly from September 2010 through April 2011.

[1] The National Home and Community-Based Services Quality Enterprise (NQE) provides technical assistance on quality to state Medicaid home and community-based services programs (HCBS) and to federal government staff responsible for overseeing these programs.

The NQE is funded by the Centers for Medicare and Medicaid Services (CMS.) under a grant to the Healthcare Business of Thomson Reuters. Professionals from Thomson Reuters and the Human Services Research Institute staff the NQE, along with consultants from other organizations.

Scope and Methodology

A report of participants in the Choices for Independence program as of the end of August 2010 was run which included cases that had been open for at least six months to allow time for a comprehensive assessment, a comprehensive case plan and for services to have been provided for at least a few months. Cases that were closed but had been closed for six months or less as of the end of August 2010 were also included.

A statistical application was used to identify a randomized and representative statewide sample that would yield a 5% confidence interval at the 95% confidence level. A proportionate sample was identified for each case management agency based on the statewide sample. See chart below:

	CFI population (as of the end of Aug. '10)	Statewide representative sample (5% confidence interval; 95% confidence level)	Proportionate sample of Brain Injury Assoc. cases
Brain Injury Assoc	33		4
Total population	2510	333	

The Brain Injury Association (BIA) and DCBCS chose to review more than the proportionate sample of only four cases and instead selected 15 cases to review. The 15 cases provided a review of one or more of each case manager's case list and would provide BIA with more feedback on its case management program.

The list of cases was distributed to BIA approximately three weeks prior to its scheduled state fiscal year 2011case management program evaluation. The program evaluation began with a brief meeting that included introductions, review of the evaluation schedule and an introduction to BIA's case record documentation system.

The program evaluation was completed in two days followed by the exit meeting held on the third day where reviewers' observations regarding the cases they reviewed were shared along with informal consultation regarding the agency's documentation system and case practice. The exit meeting included BIA's Program and Services Director and a member of the case management staff.

The program evaluation instrument was based on the three sections of the Targeted Case Management rule, i.e., He-E 805, as discussed in the Executive Summary. The program evaluation process, as was emphasized, is a quality management / quality improvement process with the expectation that each agency would produce a quality

improvement plan that includes "the remedial action taken and/or planned including the date(s) action was taken or will be taken."[2]

[2] He-M 805.10(b)(4)

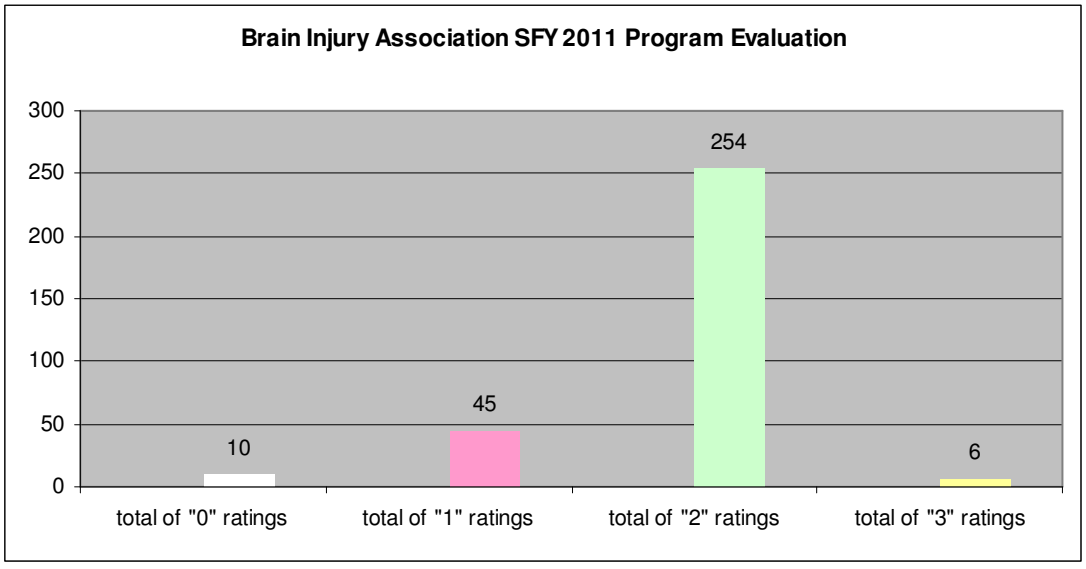
Findings and Observations

Preliminary observations were shared with the Brain Injury Association at the exit meeting held at the end of the program evaluation.

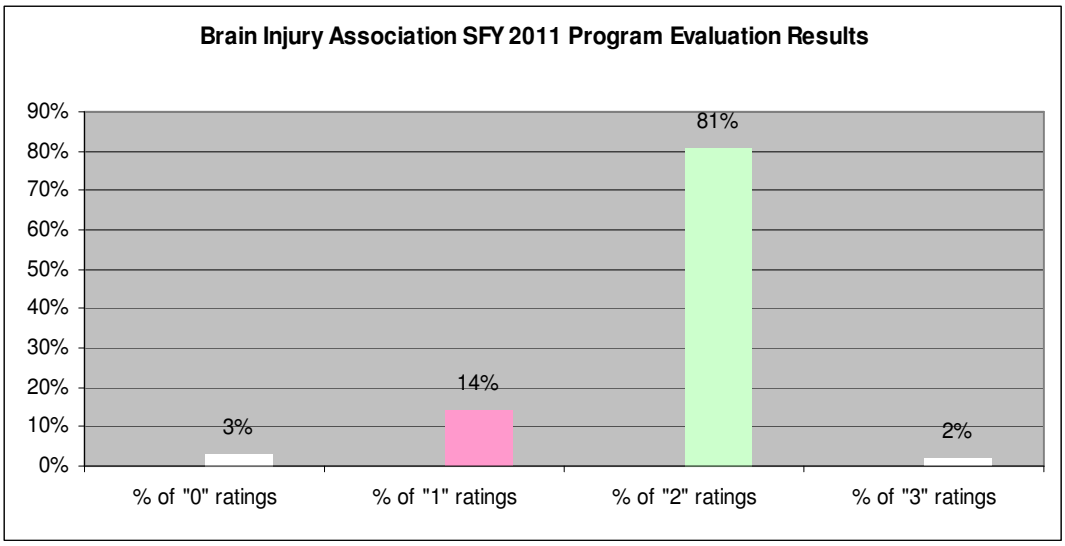
It was not possible to have gathered and assessed the data from all the case reviews for the exit meeting; the observations shared with the agency staff were a result of the daily and final wrap-up conversations with the program evaluation reviewers.

The ratings for each of the 20[3] questions are presented within the appropriate section of the report. Four questions[4] were rated for timeliness with one rated for both timeliness and quality (question #22) for a grand total of 21 ratings for each of the 15 cases.

Below and on the next page are two charts that illustrate the rating results with the vast majority of questions (81%) (254) being rated as meeting minimal expectations, i.e., rating of "2", regarding the items in the He-E 805 Targeted Case Management rule. Fourteen percent (45), of the total questions were rated as not meeting minimal expectations (rating of "1"), e.g., documentation is incomplete. Two percent (6) of the total questions were rated as exceeding minimal expectations (rating of "3"), e.g. best practice.



[3] The Case Management Program Evaluation instrument was revised with several questions combined for a total of 21 questions for SFY 2011; there were 38 questions in the CY 2009's program evaluations.
[4] Questions #1, 11, 19 and 22.



Two questions addressing timeliness were rated as zero, indicating not applicable, when the items in question were developed prior to the August 2008 adoption of the Targeted Case Management Rule, He-E 805, and thus could not legitimately be rated. Ratings of zero were recorded for the following questions when a Choices for Independence case was opened prior to August 2008:

#	BEAS Case Management Program Evaluation
1	Comprehensive Assessment is conducted within 15 working days of assignment
11	Initial Care Plan is developed within 20 working days of assignment

However, all of the 15 cases reviewed were opened after the adoption of the He-E 805 rule so entering ratings of 0 for questions #1 and 11 were not applicable.

Question #19[5] was rated as zero for cases open less than one year at the time of the review; there were four.

The team leader recorded a zero rating when an item was unfortunately overlooked by the reviewer and not rated or when the rating appeared to be grossly inconsistent with ratings on related questions.

Reviewers were encouraged to include explanatory and helpful comments as they reviewed the cases; a table of their comments, categorized as indicators of "challenges/concerns" and "positive practices" are included in the appendix of this report.

[5] Question #19: Care is updated

Comparison with CY 2009 Program Evaluation

The January 2011 Brain Injury Association program evaluation results indicated significant improvement from the 2009 results, of note is 81% of questions were rated as meeting expectations ("2") and only 14% rated as below expectations ("1") compared to 33% in CY 2009.

	CY 09	SFY 11
total of "0" ratings	34	10
total of "1" ratings	80	45
total of "2" ratings	119	254
total of "3" ratings	12	6
Total	245	315

	CY 09	SFY 11
% of "0" ratings	14%	3%
% of "1" ratings	33%	14%
% of "2" ratings	49%	81%
% of "3" ratings	5%	2%
Total	100%	100%

The CY 09 program evaluation reviewed 5 cases; the SFY 11 program evaluation sample was 15 cases.

The CY 09 program evaluation included 39 questions; the SFY 11 program evaluation included 21 questions by combining related questions and eliminating others that were determined not to be necessary.

The CY 09 program evaluation included 11 questions that were rated for both timeliness and quality (#19, 20, 21, 29, 30, 31, 33, 35, 36, 37, 38); the SFY 11 program evaluation included 1 question that rated both timeliness and quality (# 22).

The change in the SFY 11 program evaluation to not rate the comprehensive assessment questions (#1, 2, 3, 4, 5, 6, 7, 8 and 9) when cases were opened before the approval of the Targeted Case Management rule (He-E 805) resulted in more questions rated as zero and fewer rated as two.

The SFY 11 questions included five that were a combination of two or more questions from the CY 09 program evaluation and seven that were removed. See the appendix for the SFY 2011 program evaluation instrument.

	SFY 2011
1	Same question as CY 09
2	Same
3	Same
4	Same
5	Same
6	Same
7	Same
8	Same
9	Combined with #10
10	See #9
11	Same
12	Removed
13	Same
14	Combined with #15 and #33
15	See #14
16	Combined with #17
17	See #16
18	Same
19	Same
20	See #24
21	See #22
22	Combined with #21, 23, 32 and 38
23	See #21
24	Combined with # 20, 27 and 35
25	Same
26	Removed
27	See #24
28	Misnumbering; no #28
29	Same
30	Same
31	Removed
32	See #22
33	See #14
34	Removed
35	See #24
36	Removed
37	Removed
38	See #22
39	Removed

The SFY 2011 program evaluation included a review of the status of each agency's recommendations from its CY 2009 program evaluation and of the agency's policies and practices regarding BEAS state registry regulations.[6]

Recommendations

Based on the ratings and reviewer observations and comments, there are three recommendations made for the Brain Injury Association (BIA) to address in its quality improvement plan.

Comprehensive Assessment (questions #1-9)

The protocol the reviewers followed was to rate all the questions in this section only if the cases were opened on or after the rule was adopted in late August 2008.

		Questions								
		1	2	3	4	5	6	7	8	9
count of (0) ratings		0	0	0	0	0	0	0	0	0
count of (1) ratings		1	1	1	1	0	1	1	1	3
count of (2) ratings		14	14	14	14	15	14	14	14	12
count of (3) ratings		0	0	0	0	0	0	0	0	0
Total		15	15	15	15	15	15	15	15	15

This section assessed the timeliness of completing the initial comprehensive assessment (question #1) and whether each required section was adequately addressed. The comprehensive assessment is required to address a client's biopsychosocial history (#2), functional ability (#3), living environment (#4), social environment (#5) self-awareness (#6), assessment of risk (#7), legal status (#8) and community participation (#9).

The Brain Injury Association developed its *Individual Care Assessment* form after the 2009 case management program evaluation so some but not all of the cases had this completed form.

The reviewers felt that some sections of the agency's *Individual Care Assessment* form could be expanded to better address the rule requirements, e.g. the question regarding the client's risk for abuse, neglect and/or exploitation asks "in the past

[6] He-E 805.04(c): Case management agencies shall establish and maintain agency written policies and procedures regarding the following areas, and shall ensure that they are properly followed and enforced: (2) a process for confirming that each employee is not on the BEAS state registry established pursuant to RSA 161-F:49.

have there been any issues with abuse, neglect or exploitation" and does not explore the client's current risk.

This section was adequately addressed with the exception of question #9[7] regarding assessing community participation where three, or 20%, of the cases were rated as not meeting expectations. Reviewer comments included that the section was weakly addressed, that nothing was identified regarding the client's goals or interests and a case where "none" was written but with no explanation.

BIA Recommendation #1
BIA needs to improve its evaluation of community participation in its initial, comprehensive assessment by providing training, enhancing its supervision practices, monitoring the quality and completeness of its assessments, and possibly revising the form and its procedures to include the broad definition of community participation in the rule (see footnote).

Development of Care Plan (questions #11-19)

		Questions								
		10 addressed in #9	11	12 removed	13	14	15 addressed in #9	16	17 addressed in #9	18	19
count of (0) ratings			0		0	0		0	0	0	4
count of (1) ratings			4		9	10		3	0	5	0
count of (2) ratings			11		6	5		12	0	8	11
count of (3) ratings			0		0	0		0	0	2	0
Total			15		15	15		15	0	15	15

This section addressed:

- the timeliness of developing the initial (#11) and annual care plans (#19),
- whether care plans included client-specific measurable objectives and goals with timeframes (#13),
- whether care plans contained all the services and supports needed (#14),
- whether care plans addressed mitigating any risks for abuse, neglect, self-neglect and exploitation (#16), and
- whether care plans included contingency planning (#18).

[7] He-E 705.05(b)(2)(h)(1) Community participation includes the client's need or expressed desire to access specific resources such as the library, educational programs, restaurants, shopping, medical providers and any other area identified by the client as being important to his/her life.

Reviewers rated questions #13 through #18 based on the most current care plan which would be the initial care plan for cases opened less than a year or the most recent annually updated care plan for cases opened a year or more.

This section of questions proved to be the most challenging for BIA particularly questions #13 and 14:

- sixty percent (9) of the cases for question #13 were rated as one, does not meet minimal expectations;
- sixty-seven percent (10) of the cases for question #14 were rated as one.

BIA's process is such that clients sign and receive a copy of the *Profile* which is developed after the completion of the *Initial Care Assessment* where as its *Care Plan* is an on-going document that is complimentary to the monthly contact notes but for the most part does not include measurable objectives as is required for question #13. Most "actions" identify services and many are tasks to be done rather than steps towards achieving measurable objectives.

The goal of "continue to receive supports that will allow an individual to remain in the community" is a pre-written "Action" which is agreeably the significant goal but it is necessary to identify the steps needed, i.e., the "objectives", to reach that goal and the services arranged for, e.g.,

- (specific) home modification(s), and/or
- (specific) community activity (ies), and/or
- (specific) medical care, etc.

Reviewers' comments include:

- the *Care Plan* does not list the services needed or who will deliver them;
- the *Care Plan* does not describe the specific services the daughter and son will provide;
- the *Profile* indicates the client has major depression but no mental health/psychiatric care is included on the *Care Plan*;

<u>BIA Recommendation #2</u>
BIA needs to review its policy and practice regarding developing care plans, provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of its care plans to ensure that care plans:

1. contain client-specific, measurable objectives and goals with timeframes; and,
2. contain the services and supports needed to meet the objectives.

III. Monitoring and Evaluation of the Care Plan (questions #22-25)

		Questions				
		22T	22Q	23 addressed in #	24	25
count of (0) ratings		1	1	0	1	1
count of (1) ratings		0	0	0	3	1
count of (2) ratings		14	10	0	11	13
count of (3) ratings		0	4	0	0	0
Total		15	15		15	15

Reviewers rated contact and progress notes during the period under review, December 2009 to January 2011, but focused primarily on the most current six months, i.e., August 2010 through January 2011.

This section included three questions:

- the timeliness (#22T) and adequacy of contacts with clients, providers and/or family members (#22Q);
- whether services were adequate, appropriate and provided (#24); and
- whether there was evidence that the client was actively engaged in his/her care plan and that the case manager was making efforts to engage his/her client (#25).

This section was adequately addressed with question #22's results including 4 cases with ratings of 3, exceeding expectations. However, question #24, services are adequate, appropriate and provided as evidenced by the Care Plan, contact and progress notes, has 3 cases with ratings of 1, not meeting minimal expectations.

Reviewers comments included:

- (#22) monthly contact notes are comprehensive and extensive;
- (#22) contact notes are very thorough; can easily follow the plan of care;
- (#24) there is no evidence of contact with day program which client attends five times each week;
- (#24) progress notes indicate client is receiving services that are not included in care plan.

BIA Recommendation # 3
BIA needs to review its policy and practice regarding monitoring care plans, provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of staff contact notes to ensure that:

- contact notes address the client's needs (#22), and
- contact notes provide information regarding the adequacy and appropriateness of services (#24).

IV. Provider Agency Requirements/Individual Case Record (questions # 29-30)

	Questions		
		29	30
count of (0) ratings		1	1
count of (1) ratings		0	0
count of (2) ratings		14	14
count of (3) ratings		0	0
Total		15	15

This section is a strength for BIA as expectations were met for both questions for all cases in this section.

There are no recommendations for BIA regarding the case record requirement section of the program evaluation.

Quality Management and State Registry

BIA had three recommendations as a result of its CY 2009 Program Evaluation and one suggestion. BIA was encouraged to:

1.
   a. either revise its *Profile* form or develop a form, policy and procedures that meet the requirements for a comprehensive assessment; and
   b. provide training and monitor the timeliness and quality of comprehensive assessments through supervision and its quality management processes.
2.
   a. develop a care plan form, policy and procedures that meet the requirements for a comprehensive care plan; and
   b. provide training and monitor the timeliness and quality of care plans through supervision and its quality management processes

3. work with the Division of Family Assistance to establish a process that provides clients' Medicaid financial eligibility information including cost shares;
4. (suggestion) consider documenting their clients' Medicaid redetermination and Medicare Part D statuses to ensure that preparations for redeterminations and Part D enrollments are adequate and that deadlines are met; and
5. review its procedures regarding requesting relevant correspondence from clients' other providers to ensure that pertinent information is obtained and maintained in its clients' records.

Recommendation #5 does not address a requirement of the He-E 805 rule; the question was included in the program evaluation as "information only" and thus the resulting recommendation was optional for BIA and the other case management agencies to address.

BIA addressed #1, 2, 3, and 4 of the 2009 Case Management Program Evaluation recommendations in its quality improvement plan titled "2009 Case Management Program Evaluation Actions Taken" document. BIA also submits quarterly quality management reports, as required per He-E 805.10(a) and (b), that summarize the results of case record reviews and remedial actioni taken to address identified deficiencies.

BIA acknowledged that its practice is to check the BEAS State Registry prior to all prospective employee's potential employment as required by RSA 161-F:49; the process is included in its new employee packet of information.

Conclusions / Next Steps

DCBCS and BEAS appreciate the opportunity to visit the Brain Injury Association agency and to gather information through a review of a number of the agency's case records. DCBCS and BEAS acknowledge that by hosting this program evaluation, BIA spent valuable work time gathering case records, being accessible for questions, and attending the initial and exit meetings. BIA staff were very gracious and accommodating.

The 2010/2011 program evaluation is the second designed to review the Targeted Case Management rule, He-E 805, and proved to be another valuable exercise as DCBCS and BEAS continue to work internally and with their stakeholders to improve the quality of the Choices for Independence waiver program and to successfully meet the assurances and subassurances required by the Center for Medicare and Medicaid Services (CMS) of its home and community based care waiver programs for the elderly and chronically ill.[8]

[8] See the Appendix for the list of CMS Waiver Assurances and Subassurances

The Brain Injury Association is expected to develop a quality improvement plan that includes the remedial action taken and/or planned to address the three recommendations including the date(s) action was taken or will be taken. The quality improvement plan should be submitted to DCBCS Quality Management at 129 Pleasant Street, Concord NH 03301 within sixty days of the receipt of this report.

Appendices

Case Management Program Evaluation – Review Instrument

Reviewers' Comments / Observations

CMS (1915c) Waiver Assurances and Subassurances

Abbreviations

Case Management Program Evaluation – Review Instrument

Face Sheet

Case Management Agency

Name:
Address:
City/town:

Participant Name

First: Middle initial Last:

Participant (current) Living Arrangement

☐ own home
☐ adult family home
☐ assisted living facility (name of facility):
Check if client resides in one of these facilities: ☐ Meeting House ☐ Whitaker Place ☐ Summercrest
☐ congregate housing
☐ hospital (name of hospital):
☐ nursing facility (name of facility):
☐ residential care facility (name of facility):
☐ other:

Case Information

Participant's Medicaid #:
Participant's date-of-birth:
Participant's (current) Case Manager:
Date of referral to Case Management agency:
Date Case Management case closed:
Reason for case closure:

Program Evaluation Information:

Period under review (from previous annual program evaluation to date of current evaluation): to
Date of Review:
Reviewer First: Last: Agency / Position:

Findings / Ratings (enter # in white (un-filled) boxes)	
1	does not meet minimal expectations, e.g., documentation is missing
2	meets minimal expectations as established in rules
3	exceeds minimal expectations, i.e., example of best practice
0	does not apply

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(b)		**I.** Comprehensive Assessment (builds on MED, needs list, support plan)			
805.05(b)	1	Comprehensive assessment is conducted within 15 working days of assignment Include date comprehensive assessment completed.	☐		
805.02(b) and 805.05(b)(2)(a)	2	Biopsychosocial history that addresses: • Physical health • Psychological health • Decision-making ability • Social environment (addressed in question #5) • Family relationships • Financial considerations • Employment • Avocational interests, activities, including spiritual • Any other area of significance in the participant's life (substance abuse, behavioral health, development disability, and legal systems)		☐	
805.05(b)(2)(b)	3	Functional ability including ADLs and IADLs		☐	
805.05(b)(2)(c)	4	Living environment including participant's in-home mobility, accessibility, safety		☐	

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(b)(2)(d)	5	Social environment including social/informal relationships, supports, activities, avocational & spiritual interests		☐	
805.05(b)(2)(e)	6	Self-awareness including whether participant is aware of his/her medical condition(s), treatment(s), medication(s)		☐	
805.05(b)(2)(f)	7	Risk including potential for abuse, neglect or exploitation by self or others; identify whether a separate Risk Assessment has been completed		☐	
805.05(b)(2)(g)	8	Legal status including guardianship, legal system involvement, advance directives such as DPOA		☐	
805.05(b)(2)(h)(i)	9 (and 10)	Community participation including the client's need or expressed desire to access specific resources such as the library, educational programs, restaurants, shopping, medical providers and any other area identified by the client as being important to his/her life.		☐	
805.05(c)		**II.** Development of Care Plan			
805.05(c)	11	Initial Care Plan is developed within 20 working days of assignment	☐		
805.05(c)(1)	12	▪ Removed.			
805.05(c)(2)	13	▪ contains client-specific measurable objectives and goals with timeframes [review most current care plan]		☐	

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(c)(3)(a),(b)and d (c) and 10-25 GM 5.14.10, and 10-30 GM 7.16.10, and 10-34 GM 7.30.10[9]	14 (and 15 and 33)	▪ contains all the services and supports based on the clients' needs in order to remain in the community and as identified in the comprehensive assessment and MED ▪ paid[10] services (identify) b) non-paid services (identify) c) enrolled in Medicare, Part D, if appropriate *(continued on next page)* d) maximize approved Medicaid state plan services before utilizing waiver services e) identify unfulfilled needs and gaps in services f) if pertinent, has there been consultation with an agency (community mental health center, area agency, etc) regarding diagnosis and treatment [evaluate most current care plan]		☐	
805.05(c)(3)(d) and (e)	16 (and 17)	Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s) Issues identified via sentinel event reporting: • clients smoking while on oxygen • abuse (assaults) • medication abuse [evaluate most current care plan]		☐	

[9] Ensure that homemaker services (HCSP) are not actually personal care (HHCP) and that spouses are not providers
[10] Includes all paid services to be provided under Medicaid, including Medicaid state plan services, or other funding sources.

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(c)(3)(f), 805.02(l)	18	Contingency plan; the plan that addresses unexpected situations that could jeopardize the client's health or welfare, and which: • identifies alternative staffing • addresses special evacuation needs)		☐	
805.05(c)(4)(a) and, 10-17 GM 4.14.10[11]	19	Care Plan is updated: • annually, and • in conjunction with annual MED redetermination [evaluate most current care plan]		☐	Date of care plan reviewed:
805.05(d)		**III.** Monitoring and Evaluation of Care Plan[12]			
805.05(d)(1)(a) and (b) 2009 CM Program Evaluation Summary Report	22 (and 21, 23, 32 and 38)	No less than one monthly telephone contact and one face-to-face contact every 60 days. *(continue on next page)* Contacts notes with the client, other providers, and/or family members, should be frequent enough to adequately address the client's needs including readiness for annual Medicaid redetermination; location and type of contact (phone, face-face) should be specified. Describe frequency of contacts and with whom.	☐	☐	
805.05(d)(2); and 805.04(f)(7) 10-25 GM 5.14.10[13]	24 (and 20, 27 and 35)	Services are adequate, appropriate, provided as evidenced by: ○ CM agency Care Plan (see ques. #14, 16, 18, 19) ○ CM agency contact notes required for each client ○ Progress notes that reflect areas contained in the care		☐	

[11] Annual redetermination of medical eligibility for the CFI program includes review of the client's needs and process to authorize services
[12] Current terminology: MED process includes development of "service plans" by BEAS Long Term Care Nurse; Case Management agencies develop "care plans"
[13] Per 10-25 GM 5.14.10 (05/14/10): CM must "document types and amount of: home health services, personal care, physical care, physical therapy, occupational therapy, speech therapy, adult medical day, private duty nursing

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
		plan, including authorizations for new or changed services			
805.05(d)(3)	25	Participant is actively engaged in care plan – and case manager is making adequate and appropriate efforts to engage the participant (see contact and progress notes, e-mails and correspondence with clients and providers, notes re case specific meetings with providers)		☐	
805.05(d)(4)	26	Removed			
	28	Instrument misnumbered with #28 overlooked			
805.04		Provider Agency Requirements			
805.04(f) 10-25 GM 5.14.10		**IV. Case management agencies shall maintain an individual case record which includes**:			
805.04(f)(1)	29	Face sheet including current (updated annually with the Care Plan and MED (see #19)) demographic and other information: name, DOB, address, Medicaid #, emergency contact person, phone number, address.		☐	
805.04(f)(2)	n/a	Comprehensive assessment (see 805.05(b))			
805.04(f)(3)	n/a	Care plan (see 805.05(c))			
805.04(f)(4)	30	Current MED needs list/support plan		☐	
805.04(f)(5)	31	Removed			
805.04(f)(6)	34	Removed			
805.04(f)(8)		Contact notes (see 805.05(d)(1))			
Info only	36	Removed.			
Info only	37	Removed			
805.04(f)(10)	39	Removed			

Total questions: 21

General Observations
Include observations pertinent to the case reviewed that have not otherwise been captured by the questionnaire and that would be useful to record as evidence of best practice and/or evidence of challenges to providing effective, appropriate and quality care.

Program Evaluation Completed: Date:
Name:

Quality Management
Program Evaluation Reviewed: Date:
Name:

Original Filed: DCBCS Quality Management
Copy Filed: BEAS Quality Management

Reviewers Comments / Observations

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
I. Comprehensive Assessment			
1	Comprehensive assessment is conducted within 15 working days		Client was referred on 02/16/10 and *Individual Care Assessment* completed on 04/04/10 but there are many contact notes between Feb. and April explaining attempts to contact client.
2	Biopsychosocial history	Indicated "N/A" for employment; should include an explanation.	Assessment is complete with each section having a narrative. All categories are addressed though no mention of spiritual interests.
3	Functional ability, including ADLs and IADLs	There is a list of personal care needs, however none are circled or give any indication if assistance is needed.	Well documented. Could benefit from explanation of needs identified.
4	Living environment		Well documented
5	Social environment	Weakly addressed (2) Family relationships are included but nothing else about client's social environment.	
6	Self-awareness		Well documented
7	Risk, including potential for abuse, neglect or exploitation by self or others	*Individual Care Assessment* indicates that risk is low but does not explain why	Fire and Safety section in addition to Risk for abuse/neglect/exploitation section.

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
			Risk Assessment includes providers' actions.
8	Legal status		
9	Community participation	Addressed but weakly "Community participation" checked as a goal on *Initial Care Assessment* but nothing more to describe/identify specific goal(s)/interest(s) Assessment states "none" with no explanation re client's status re this issue. Informal Supports: Family/Community/Social Supports section (#2) not completed.	Documentation noted there were no community connections. Medical providers identified, client attends day program and is close to his adult children but nothing else explored. Client is going to a local gym to use a treadmill and the pool at the local Y as his therapist recommended.
10	Address in #9		
II. Development of Care Plan			
11	Initial Care plan is developed within 20 working days of assignment	Care plan developed approximately 6 weeks after referral to agency.	Care Plan completed on same day as comprehensive assessment (3)
12	Removed		
13	Care plan contains measurable objectives and goals with timeframes	"Supports that allow client to remain in community" are not specified. *Care Plan* is list of action steps but not equal to measurable objectives. "To remain in the community" and "develop an emergency plan" do not have timeframes or more specific	Care Plan includes measurable goals (2) Objectives are measurable and client specific. Care Plan is comprehensive and has appropriate Actions that refer to services and not just action steps,

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		goals. Goal states: "(name) is quite independent and drives to all medical appointments, shops, so on". Both the target date and completion date is month after care plan completed. Needs listed on MED not included. Client's day program attendance increased from 2x/week to 3x/week when referred to BIA; no goals or other services identified. Care plan does not list the services needed or who will deliver them. Client in assisted living's care plan does not specify what the facility and CM are addressing.	i.e., ▪ case management, ▪ refer to (name of agency) for 24 hours for PCS services, ▪ refer to (name of agency) for 32 hours of PCSP services, ▪ refer to MOW for delivery 7x/week
14 (and 15 and 33)	Care plan contains all the services and supports based on the participants' needs in order to remain in the community and as identified in the comprehensive assessment and MED a) Paid services (identify) b) Non-paid services (identify) c) Enrolled in Medicare, Part D, if appropriate d) Maximize approved Medicaid state plan services e) Identify unfulfilled needs and gaps in services f) Consultation re diagnosis and treatment,	Care Plan does not list specific services being provided by the various agencies. (3) Care plan does not describe the specific services daughter and son will provide - only that they provide day-to-day care. The *Profile* indicates client has major depression but nothing mentioned on	Copies of providers' notes, correspondence in case file. Objectives are specific however the care plan does not mention other paid/non-paid services client is receiving other than adult day.

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
	if pertinent	Care Plan of mental health/psychiatric care. Community services and supports not identified, e.g., PCSP and nursing services. "Hire new CFI providers" should have identified the services needed and the specific providers. MED states client requires assistance with some ADLs and some IADLs but they are not included on Care Plan. MED also lists nursing services for medi-planner but assessment states that the client does not take any medication.	
15	Addressed in #14		
16 (and 17)	Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s)	Case note indicated client thinks niece's husband is stealing from her (client). No reference in contact notes or care plan of any follow-up to this concern. None reported however progress notes mention that husband can become verbally abusive to care givers when he does not feel that they are caring for his wife appropriately. Assessment indicated risk for abuse is "low" but there is no explanation for	Risk Assessment completed. *Care Plan* includes 3 reports to Adult Protective Services (APS) with risk management meeting held with APS, community providers, and BIA. Risk Assessment's "action(s) taken to decrease risk" are good but should include timeframes. The Risk Assessment noted that no risk was identified but the writer

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		that conclusion.	wrote he/she would note any risk that develops and take appropriate action.
17	Addressed in #16		
18	Contingency plan addresses unexpected situations, identifies alternative staffing and special evacuation needs	Plan for alternative staffing, if needed, not included (2) "Develop an Emergency Plan" identified (06/04/09) but no target date or completed date or discussion of what should be included. "Emergency Plan" located but was not dated and did not address alternative staffing. The assessment states there is no contingency plan; no explanation provided. Client's significant other noted to becoming overwhelmed with providing care but no back-up plans indicated	*Emergency Plan* includes whether live-in PCSP is present or not, ill or not and includes smoking protocol. *Emergency Plan* includes client's allergies of which there are 7. Record states that client has an evacuation plan, that it is practiced monthly and that local fire department is aware of client's limited mobility and need for assistance.
19	Care plan is updated: annually, and in conjunction w/annual MED	*Care Plan* is updated as needed but is not comprehensively updated on an annual basis.	*Care Plan* is continuously updated.
20	Addressed in #24		
21	Addressed in #22		
III. Monitoring and Evaluation of Care Plan			
22 (and 21,	No less than 1 monthly telephone contact and 1 face-to-face contact every 60 days	Some notes included month and year but not the day of the contact.	Very frequent contact with client, boyfriend/PCSP, APS and other providers.

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
23, 32 and 38)			Monthly case notes include status report which identifies current issues. Contact notes are very thorough; can easily follow the plan of care. There are many contacts each month with explicit details. The client's needs are being met. Monthly Contact Notes are comprehensive and extensive; this case required collaboration among several agencies – all of which is very well documented. There are contacts every month but it is difficult to see what role the case manager is playing (residential care case)
23	Addressed in #22		
24 (and 20, 27 and 35)	Services are adequate, appropriate, provided as evidenced by: • CM agency Care Plan • CM agency contact notes • Progress notes	Discrepancy in contact notes: July 2009 note states "there has been no need for interpreter services, her English skills are fine"; Dec. 2009 note states that "(name) does not speak English, so all communication needs to happen with the daughter or son."	Concerns noted about boyfriend/PCSP not providing care he is paid for resulting in risk to client.

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		No evidence of mental health/psychiatric services though *Initial Care Assessment* indicated major depression. No evidence of contact with day program which client attends 5x/week. Progress notes indicate client is receiving PCSP and Home Health Aide and medical appointments in Boston with none of these noted in the care plan. Progress notes do not reflect what case manager is providing or assessing (assisted living).	
25	Participant is actively engaged in Care Plan	Progress notes do not reflect case manager's interaction with the client (assisted living).	Case manager meets regularly with client and his wife who is client's DPOA. Case manager spends significant amount of time talking with client and her boyfriend/PCSP about client's needs, PCSP responsibilities and risk PCSP's lack of care creates for client. [Client continuously declines agency-directed PCSP services as she wants her boyfriend

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
			as PCSP]. Client is abusive to caretakers; case manager addresses concerns with her and problem solves with the agencies to ensure that the client receives the services she needs. Client has followed all recommendations for exercise and PT and OT therapies to the point that client went to local store to try on a glove by himself to test his progress. Client is asked about the providers and the services he is receiving.
26	Removed		
27	Addressed in #24		
28	Error in numbering		
IV. Provider Agency Requirements / Individual Case Records			
29	Face sheet		Includes CFI start date, date transferred from former case management agency, CFI redetermination due dates and comprehensive contact list.
30	Current MED needs list / support plan		
31	Removed		
32	Addressed in question #22		
33	Addressed in question #14		

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
34	Removed		
35	Addressed in question #24		
36	Removed		
37	Removed		
38	Removed		
39	Removed		

General Observations	
Challenges / Concerns	**Positive practices**
Face sheet: suggestion is to include the case manager's name and date of referral to the agency.	Monthly contact notes include the number and type of contacts within the month.
Care Plan is updated continuously but a comprehensive, annual update is not current policy and practice.	There is a contact sheet with all providers' names and services listed including BEAS contact information, doctor's phone number and directions to client's residence.
Individual Care Assessment, question #7 (Risk for abuse/neglect/exploitation) asks: "in the past have there been any issues with abuse, neglect or exploitation". Should also assess current status of risk of abuse, neglect and/or exploitation.	*Profile* is comprehensive; includes list of services and frequency.
Individual Care Assessment, question #2 (Information Supports: Family/Community/Social Supports) asks for information about a client's help and supports but doesn't inquire about a client's needs or desires to participate in his/her community, e.g. library, educational programs, etc.	APS involvement has been very helpful especially working with the area agency which hadn't been very cooperative in coordinating services, e.g. home modifications. APSW involved with getting hearing aids, working with client on her finances, setting up transportation, etc.
Adult Protective Services provided case management for several months in a case; concern about duplication of services.	*Profile* form and *Individual Care Assessment* provide good overview and assessment
There is a discrepancy between the MED and the assessment in that the MED lists, among other things, a medi-planner but the initial assessment states that the client does not take any medication.	
Reviewer questioned role of case management in assisted living facility as documentation does not reflect that case management is providing a needed service.	

CMS (1915c) Waiver Assurances and Subassurances		
Assurances	**Subassurances**	
Level of Care	Persons enrolled in the waiver have needs consistent with an institutional level of care	
	Subassurances	a. An evaluation for Level of Care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future
		b. The levels of care of enrolled participants are re-evaluated at least annually or as specified in the approved waiver
		c. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care
Service Plan	Participants have a service plan that is appropriate to their needs and that they receive the services/supports specified in the plan	
	Subassurances	a. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
		b. The state monitors service plan development in accordance with its policies and procedures
		c. Service plans are updated / revised at least annually or when warranted by changes in the waiver participant's needs.
		d. Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan
		e. Participants are afforded choice: e.1. between waiver services and institutional care e.2. between / among waiver services, and e.3. providers

CMS (1915c) Waiver Assurances and Subassurances		
Assurances	**Subassurances**	
Qualified Providers	Waiver providers are qualified to deliver services / supports	
	Subassurances	a. The state verifies that providers, initially and continually, meet required licensure and / or certification standards and adhere to other standards prior to their furnishing waiver services
		b. The state monitors non-licensed / non-certified providers to assure adherence to waiver requirements
		c. The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
Health and Welfare	Participants' health and welfare are safeguarded and monitored	
	Subassurance	The state, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
Financial Accountability	Claims for waiver services are paid according to state payment methodologies	
	Subassurance	State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
Administrative Authority	The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.	
	Subassurance	The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local / regional non-state agencies (if appropriate) and contracted entities.

Abbreviations

Abbreviation	Terminology
ADL	Activities of Daily Living
BEAS	Bureau of Elderly and Adult Services
BIA	Brain Injury Association
CFI	Choices for independence program, formerly known as the Home and Community Based Care Services – Elderly and chronically Ill Waiver Program (HCBC-ECI)
CM	Case Management or Case Manager
CMS	Center for Medicare and Medicaid Services
CY	Calendar Year
DCBCS	Division of Community Based Care Services
DPOA	Durable Power of Attorney
HCBC – ECI	Home and Community Based Care Services – Elderly and Chronically Ill Waiver Program renamed the Choices for Independence program (CFI)
IADL	Instrumental Activities of Daily Living
LOC	Level of Care
NF	Nursing Facility
PCP	Primary Care Physician
PCA	Personal Care Attendant
PCSP	Personal Care Service Provider
PES	Participant Experience Survey
POC	Plan of Care
SFY	State Fiscal Year